STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

March 4, 1991
Letter No.: 91-16

TO: All County Welfare Directors
All County Administrative Officers

SUBJECT: SNEEDE v. KIZER SELF-IDENTIFICATION FORM

The purpose of this letter is to transmit a camera-ready copy of the Sneede v. Kizer self-identification questionnaire counties may use to identify potential Sneede class members. This form is designed to be sent out and then returned by beneficiaries with their status report. Counties using this form should send one with the status report to all AFDC - MN or MI beneficiaries at least once in the first three months of Sneede implementation (April 1991 through June 1991). Counties which use monthly status reports need only send this form once during this period. It is important to remember that the use of this form is optional, as described below.

Counties have several options for identifying beneficiaries as potential Sneede eligibles at the time the status report is returned. These options include: 1) reproduce the attached form and send it out with the status report; 2) put this approved language on card stock or any different size format, in order to accommodate their own internal procedures, and send it with the status report; or 3) review all AFDC - MN and MI cases when the status report is returned and not use this form. Whichever option counties choose, it is essential that the Sneede evaluation and disposition be adequately documented in the case record. It is recommended that this documentation be placed on a document which will remain in the case record for more than one year as the reporting requirements to the plaintiff's attorney is fifteen months.

Use Of The Self-Identification Form

> Upon return of the questionnaire, if any box is checked yes, pull the case file and review the appropriate documents to determine if Sneede procedures would apply at any time from 1/1/90 to the date of the review. If the review to determine if Sneede procedures already performed when the initial class notice was returned, the counties will not need to conduct a second review. We recommend that any case for which a form was returned with a box checked yes be flagged as a potential Sneede case. These

cases must be reevaluated at the time of any reported income change and at the redetermination.

If the case has a zero share of cost and does not contain an excluded child, file the response in the case file. These cases will not be reported on the Sneede Caseload Movement and Activity Report.

If the case has a share of cost or the record indicates an excluded child, review the case for Sneede factors. If Sneede factors are present, redetermine the property eligibility and/or share of cost for the current month and continuing using the Sneede procedures. Count as a Sneede case identified at the time of the status report on Section 8.a. of the Sneede Caseload Movement and Activity Report regardless of Sneede determination results. If Sneede factors were present from 1/1/90 to date of review, pend the retro portion of the case until procedures are issued on retro claiming (these procedures are still being developed).

If the beneficiary checks all the boxes no, file the response in the case file. If the beneficiary fails to return the Sneede self-identification form with the status report, note this fact on the status report or document this in the case record. There is no penalty to the beneficiary for not returning this form with the status report since it is not part of the status report and does not subject the beneficiary to any negative action. Counties are not required to perform a further review of cases in either of these categories for Sneede factors until redetermination or unless contacted by the beneficiary.

If you have any comments or questions regarding this information, please contact Larry Lucero at (916) 322-5068.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

IMPORTANT NOTICE
SNEEDE V. KIZER
YOU MAY DESERVE MORE MEDI-CAL BENEFITS!

A federal court found that Medi-Cal wrongly denied some people their Medi-Cal cards and told others their share of cost was higher than it should have been. You may be one of these people. Please answer the four questions below, fill in your name, Medi-Cal case number and telephone number and return this form with your Medi-Cal status report.

1. Is there a stepparent or stepchild living with you? ☐ Yes ☐ No
2. Are you unmarried and living with a partner, where your partner is also the parent of any of your children? ☐ Yes ☐ No
3. Are you living with a child under age 21 who has his own income? ☐ Yes ☐ No
4. Are you a caretaker relative of a child who is not your son or daughter (e.g., you are a grandparent, aunt, uncle, etc.,) and you and the child both get Medi-Cal? ☐ Yes ☐ No

IMPORTANT: If you answer "yes" to ANY of the questions, your worker will check your case to see if you or anyone living with you should get more benefits.

Your name	Medi-Cal Case Number	Telephone Number

RETURN THIS FORM WITH YOUR MEDI-CAL STATUS REPORT

AVISO IMPORTANTE
SNEEDE V. KIZER
¡USTED PUEDE MERECER MAS BENEFICIOS DE MEDI-CAL!

Una corte federal determinó que Medi-Cal negó erróneamente a algunas personas sus tarjetas de Medi-Cal y les dijo a otras que su parte del costo era más alta que lo que debiera haber sido. Usted puede ser una de estas personas. Por favor conteste las cuatro preguntas enseguida. Ponga su nombre, número de caso de Medi-Cal, número de teléfono, y regrese esta forma con su "Informe de su Estado Financiero para Medi-Cal".

1. ¿Hay un padrastro/madrastra o hijastro(a), viviendo con usted? ☐ Sí ☐ No
2. ¿Es usted soltero(a) y está viviendo con un(a) compañero(a), quien es también el padre/madre de alguno de sus hijos? ☐ Sí ☐ No
3. ¿Está viviendo con un niño menor de 21 años quien tiene sus propios ingresos? ☐ Sí ☐ No
4. ¿Es usted el pariente encargado de un niño que no es su hijo (por ejemplo usted es el abuelo(a), tío, tía, etc.) y tanto usted como el niño reciben Medi-Cal? ☐ Sí ☐ No

IMPORTANTE: Si responde "sí" a CUALQUIERA de las preguntas, su trabajador(a) volverá a examinar su caso para ver si usted o alguien que viva con usted pudiera reunir los requisitos para recibir más beneficios.

Su nombre	Número de caso de Medi-Cal	Número de teléfono

REGRESE ESTA FORMA CON SU "INFORME DE SU ESTADO FINANCIERO PARA MEDI-CAL"